RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

● = One item required to trigger

❷ = Two items required to trigger

✱ = One of these three items, plus at least one other item required to trigger

ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1		●																			B2a
B2b	Long term memory	1		●																			B2b
B4	Decision making	1,2,3		●																			B4
B4	Decision making	3					●																B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3				●																	C1
C4	Understood by others	1,2,3				●																	C4
C6	Understand others	1,2,3		●		●																	C6
C7	Change in communication	2																		●			C7
D1	Vision	1,2,3			●																		D1
D2a	See vision problem	2			●																		D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1p
E1p	Repetitive movement	1,2																		●			E1p
E1o	Withdrawal from activities	1,2								●													E1o
E2	Mood persistence	1,2									●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3											●										E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3										●											E4aA - E4eA
E5	Change in behavioral symptoms	1										●											E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Establishes own goals	✓								●													F1d
F2a to F2d	Unsettled relationships	✓								●													F2a to F2d
F3a	Sense of lost roles	✓								●													F3a
F3b	Lost roles	✓								●													F3b
F3c	Daily routine different	✓								●													F3c
G1aA - G1jA	ADL self-performance	1,2,3,4					●																G1aA - G1jA
G1aA	Bed mobility	1,2,3,4																	●				G1aA
G2A	Bathing	1,2,3,4					●																G2A
G3b	Balance while sitting	1,2,3																		●			G3b
G6a	Bedfast	✓																	●				G6a
G6a,b	Resident, staff believe capable	✓					●																G6a,b
H1a	Bowel incontinence	1,2,3,4																	●				H1a
H1b	Bladder incontinence	2,3,4						●															H1b
H2b	Constipation	✓																		●			H2b
H2d	Fecal impaction	✓																		●			H2d
H3c,d,e	Catheter use	✓						●															H3c,d,e
H3g	Use of bedrails	✓						●															H3g
I1i	Hypotension	✓																		●			I1i
I1j	Peripheral vascular disease	✓																	●				I1j
I1ee	Depression	✓																		●			I1ee
I1ii	Cataracts	✓			●																		I1ii
I1ll	Glaucoma	✓			●																		I1ll
I2	UTI	✓																●					I2
I3	Dehydration diagnosis	276.5																●					I3
J1e	Weight fluctuation	✓																●					J1e
J1c	Dehydrated	✓																●					J1c
J1d	Insufficient fluid	✓																●					J1d
J1f	Dizziness	✓												●						●			J1f
J1h	Pain	✓																●					J1h
J1i	Hallucinations	✓																		●			J1i
J1j	Internal bleeding	✓																●					J1j
J1k	Lung aspirations	✓																		●			J1k
J1o	Syncope	✓																					J1o

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

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MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	MDS ITEM
J1h	Unsteady gait	✓																				J1h
J4a,b	Fell	✓												●						●		J4a,b
J4c	Hip fracture	✓																		●		J4c
K1b	Swallowing problem	✓																		●		K1b
K1c	Mouth pain	✓																●				K1c
K3a	Weight loss	1													●							K3a
K4a	Taste alteration	✓													●							K4a
K4c	Leave 25% food	✓													●							K4c
K5a	Parenteral/IV feeding	✓													●		●					K5a
K5b	Feeding tube	✓														●	●					K5b
K5c	Mechanically altered	✓													●							K5c
K5d	Syringe feeding	✓													●							K5d
K5e	Therapeutic diet	✓													●							K5e
L1a,c,d,e	Dental	✓																●				L1a,c,d,e
L1f	Daily cleaning teeth	Not ✓																●				L1f
M2a	Pressure ulcer	2,3,4													●							M2a
M2a	Pressure ulcer	1,2,3,4																	●			M2a
M3	Previous pressure ulcer	1																	●			M3
M4c	Impaired tactile sense	✓																	●			M4c
N1a	Awake morning	✓										❷										N1a
N2	Involved in activities	0										❷										N2
N2	Involved in activities	2,3									●											N2
N5a,b	Prefers change in daily routine	1,2									●											N5a,b
O4a	Antipsychotics	1-7																		✱		O4a
O4b	Antianxiety	1-7												●						✱		O4b
O4c	Antidepressants	1-7												●						✱		O4c
O4e	Opioids	1-7															●					O4e
P4c	Trunk restraint	1,2												●							●	P4c
P4c	Trunk restraint	2																	●			P4c
P4d	Limb restraint	1,2																			●	P4d
P4e	Chair prevents rising	1,2																			●	P4e

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month ___ Day ___ Year ____	
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility	
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE		
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	*(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)* Prior stay at this nursing home — a. Stay in other nursing home — b. Other residential facility—board and care home, assisted living, group home — c. MH/psychiatric setting — d. MR/DD setting — e. *NONE OF ABOVE* — f.	
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]		
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree	
8.	LANGUAGE	*(Code for correct response)* a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify	
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes	
10.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to AB11) — a. MR/DD with organic condition Down's syndrome — b. Autism — c. Epilepsy — d. Other organic condition related to MR/DD — e. MR/DD with no organic condition — f.	
11.	DATE BACKGROUND INFORMATION COMPLETED	Month ___ Day ___ Year ____	

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)	*(Check all that apply. If all information UNKNOWN, check last box only.)*	
		CYCLE OF DAILY EVENTS	
		Stays up late at night (e.g., after 9 pm)	a.
		Naps regularly during day (at least 1 hour)	b.
		Goes out 1+ days a week	c.
		Stays busy with hobbies, reading, or fixed daily routine	d.
		Spends most of time alone or watching TV	e.
		Moves independently indoors (with appliances, if used)	f.
		Use of tobacco products at least daily	g.
		NONE OF ABOVE	h.
		EATING PATTERNS	
		Distinct food preferences	i.
		Eats between meals all or most days	j.
		Use of alcoholic beverage(s) at least weekly	k.
		NONE OF ABOVE	l.
		ADL PATTERNS	
		In bed/clothes much of day	m.
		Wakens to toilet all or most nights	n.
		Has irregular bowel movement pattern	o.
		Showers for bathing	p.
		Bathing in PM	q.
		NONE OF ABOVE	r.
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	s.
		Usually attends church, temple, synagogue (etc.)	t.
		Finds strength in faith	u.
		Daily animal companion/presence	v.
		Involved in group activities	w.
		NONE OF ABOVE	x.
		UNKNOWN—Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:			
a. Signature of RN Assessment Coordinator			Date
b. Signatures	Title	Sections	
c.			Date
d.			Date
e.			Date
f.			Date
g.			Date

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period* — Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) — Month — Day — Year

5. MARITAL STATUS
1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY
(Billing Office to indicate; check all that apply in last 30 days)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT
(Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed)

a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. *Codes for assessments required for Medicare PPS or the State*
1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN
(Check all that apply)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES
(For those items with supporting documentation in the medical record, check all that apply)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE
(Persistent vegetative state/no discernible consciousness)
0. No 1. Yes (If yes, skip to Section G)

2. MEMORY
(Recall of what was learned or known)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY
(Check all that resident was normally able to recall during last 7 days)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(Made decisions regarding tasks of daily life)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS
(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS
Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING
(With hearing appliance, if used)
0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES
(Check all that apply during last 7 days)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION
(Check all used by resident to make needs known)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD
(Expressing information content—however able)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY
(Code for speech in the last 7 days)
0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS
(Understanding verbal information content—however able)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING
Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	*(Ability to see in adequate light and with glasses if used)* 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(Code for indicators observed in last 30 days, irrespective of the assumed cause)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"*

b. Repetitive questions—e.g., *"Where do I go; What do I do?"*

c. Repetitive verbalizations—e.g., calling out for help, *("God help me")*

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., *"I am nothing; I am of no use to anyone"*

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

4. BEHAVIORAL SYMPTOMS

(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL		

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
   —Weight-bearing support
   —Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

Resident _____ Numeric Identifier _____

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)*		
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* Cane/walker/crutch [a.]; Wheeled self [b.]; Other person wheeled [c.]; Wheelchair primary mode of locomotion [d.]; *NONE OF ABOVE* [e.]		
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* Bedfast all or most of time [a.]; Bed rails used for bed mobility or transfer [b.]; Lifted manually [c.]; Lifted mechanically [d.]; Transfer aid (e.g., slide board, trapeze, cane, walker, brace) [e.]; *NONE OF ABOVE* [f.]		
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs [a.]; Direct care staff believe resident is capable of increased independence in at least some ADLs [b.]; Resident able to perform tasks/activity but is very slow [c.]; Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings [d.]; *NONE OF ABOVE* [e.]		
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)* 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time			
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days [a.]; Constipation [b.]; Diarrhea [c.]; Fecal impaction [d.]; *NONE OF ABOVE* [e.]		

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal [f.]
		Bladder retraining program	b.	Pads/briefs used [g.]
		External (condom) catheter	c.	Enemas/irrigation [h.]
		Indwelling catheter	d.	Ostomy present [i.]
		Intermittent catheter	e.	*NONE OF ABOVE* [j.]
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*		
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis [v.]
				Multiple sclerosis [w.]
		Diabetes mellitus	a.	Paraplegia [x.]
		Hyperthyroidism	b.	Parkinson's disease [y.]
		Hypothyroidism	c.	Quadriplegia [z.]
		HEART/CIRCULATION		Seizure disorder [aa.]
		Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA) [bb.]
		Cardiac dysrhythmias	e.	Traumatic brain injury [cc.]
		Congestive heart failure	f.	PSYCHIATRIC/MOOD
		Deep vein thrombosis	g.	Anxiety disorder [dd.]
		Hypertension	h.	Depression [ee.]
		Hypotension	i.	Manic depression (bipolar disease) [ff.]
		Peripheral vascular disease	j.	Schizophrenia [gg.]
		Other cardiovascular disease	k.	PULMONARY
		MUSCULOSKELETAL		Asthma [hh.]
		Arthritis	l.	Emphysema/COPD [ii.]
		Hip fracture	m.	SENSORY
		Missing limb (e.g., amputation)	n.	Cataracts [jj.]
		Osteoporosis	o.	Diabetic retinopathy [kk.]
		Pathological bone fracture	p.	Glaucoma [ll.]
		NEUROLOGICAL		Macular degeneration [mm.]
		Alzheimer's disease	q.	OTHER
		Aphasia	r.	Allergies [nn.]
		Cerebral palsy	s.	Anemia [oo.]
		Cerebrovascular accident (stroke)	t.	Cancer [pp.]
		Dementia other than Alzheimer's disease	u.	Renal failure [qq.]
				NONE OF ABOVE [rr.]
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*		
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia [g.]
		Clostridium difficile (c. diff.)	b.	Sexually transmitted diseases [h.]
		Conjunctivitis	c.	Tuberculosis [i.]
		HIV infection	d.	Urinary tract infection in last 30 days [j.]
		Pneumonia	e.	Viral hepatitis [k.]
		Respiratory infection	f.	Wound infection [l.]
				NONE OF ABOVE [m.]
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____ b. _____ c. _____ d. _____ e. _____		

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*		
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo [f.]
				Edema [g.]
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Fever [h.]
				Hallucinations [i.]
		Inability to lie flat due to shortness of breath	b.	Internal bleeding [j.]
				Recurrent lung aspirations in last 90 days [k.]
		Dehydrated; output exceeds input	c.	Shortness of breath [l.]
				Syncope (fainting) [m.]
		Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.	Unsteady gait [n.]
				Vomiting [o.]

Resident _____ Numeric Identifier _____

2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)* a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (*skip to J4*) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
3.	PAIN SITE	*(If pain present, check all sites that apply in last 7 days)* Back pain a. Bone pain b. Chest pain while doing usual activities c. Headache d. Hip pain e. Incisional pain f. Joint pain (other than hip) g. Soft tissue pain (e.g., lesion, muscle) h. Stomach pain i. Other j.	
4.	ACCIDENTS	*(Check all that apply)* Fell in past 30 days a. Fell in past 31-180 days b. Hip fracture in last 180 days c. Other fracture in last 180 days d. *NONE OF ABOVE* e.	
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) a. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem b. End-stage disease, 6 or fewer months to live c. *NONE OF ABOVE* d.	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem a. Swallowing problem b. Mouth pain c. *NONE OF ABOVE* d.	
2.	HEIGHT AND WEIGHT	*Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) b. WT (lb.)	
3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods a. Regular or repetitive complaints of hunger b. Leaves 25% or more of food uneaten at most meals c. *NONE OF ABOVE* d.	
5.	NUTRITIONAL APPROACHES	*(Check all that apply in last 7 days)* Parenteral/IV a. Feeding tube b. Mechanically altered diet c. Syringe (oral feeding) d. Therapeutic diet e. Dietary supplement between meals f. Plate guard, stabilized built-up utensil, etc. g. On a planned weight change program h. *NONE OF ABOVE* i.	
6.	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section L if neither 5a nor 5b is checked)* a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night a. Has dentures or removable bridge b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) c. Broken, loose, or carious teeth d. Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff f. *NONE OF ABOVE* g.	

SECTION M. SKIN CONDITION

1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam* a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Ulcer Stage
2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)* a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during last 7 days)* Abrasions, bruises a. Burns (second or third degree) b. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) c. Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster d. Skin desensitized to pain or pressure e. Skin tears or cuts (other than surgery) f. Surgical wounds g. *NONE OF ABOVE* h.	
5.	SKIN TREATMENTS	*(Check all that apply during last 7 days)* Pressure relieving device(s) for chair a. Pressure relieving device(s) for bed b. Turning/repositioning program c. Nutrition or hydration intervention to manage skin problems d. Ulcer care e. Surgical wound care f. Application of dressings (with or without topical medications) other than to feet g. Application of ointments/medications (other than to feet) h. Other preventative or protective skin care (other than to feet) i. *NONE OF ABOVE* j.	
6.	FOOT PROBLEMS AND CARE	*(Check all that apply during last 7 days)* Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems a. Infection of the foot—e.g., cellulitis, purulent drainage b. Open lesions on the foot c. Nails/calluses trimmed during last 90 days d. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) e. Application of dressings (with or without topical medications) f. *NONE OF ABOVE* g.	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning a. Afternoon b. Evening c. *NONE OF ABOVE* d.	
		(If resident is comatose, skip to Section O)	
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)* Own room a. Day/activity room b. Inside NH/off unit c. Outside facility d. *NONE OF ABOVE* e.	
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)* Cards/other games a. Crafts/arts b. Exercise/sports c. Music d. Reading/writing e. Spiritual/religious activities f. Trips/shopping g. Walking/wheeling outdoors h. Watching TV i. Gardening or plants j. Talking or conversing k. Helping others l.	

Resident _____ Numeric Identifier _____

5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
2.	NEW MEDICATIONS	*(Resident currently receiving medications that were initiated during the last 90 days)* 0. No 1. Yes	
3.	INJECTIONS	*(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)* a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*

TREATMENTS		PROGRAMS	
Chemotherapy	a.	Alcohol/drug treatment program	m.
Dialysis	b.	Alzheimer's/dementia special care unit	n.
IV medication	c.	Hospice care	o.
Intake/output	d.	Pediatric unit	p.
Monitoring acute medical condition	e.	Respite care	q.
Ostomy care	f.	Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
Oxygen therapy	g.	*NONE OF ABOVE*	s.
Radiation	h.		
Suctioning	i.		
Tracheostomy care	j.		
Transfusions	k.		
Ventilator or respirator	l.		

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]
(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS

(Check all interventions or strategies used in last 7 days—no matter where received)

Special behavior symptom evaluation program	a.
Evaluation by a licensed mental health specialist in last 90 days	b.
Group therapy	c.
Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
Reorientation—e.g., cueing	e.
NONE OF ABOVE	f.

3. NURSING REHABILITATION/ RESTORATIVE CARE

Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)

a. Range of motion (passive)		f. Walking	
b. Range of motion (active)		g. Dressing or grooming	
c. Splint or brace assistance		h. Eating or swallowing	
TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care	
d. Bed mobility		j. Communication	
e. Transfer		k. Other	

4.	DEVICES AND RESTRAINTS	*(Use the following codes for last 7 days:)* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. — Full bed rails on all open sides of bed	
		b. — Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*	
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*	
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*	
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*	
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident:	0. No	1. Yes		
		b. Family:	0. No	1. Yes	2. No family	
		c. Significant other:	0. No	1. Yes	2. None	

2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month — Day — Year

c. Other Signatures	Title	Sections	Date
d.			Date
e.			Date
f.			Date
g.			Date
h.			Date

3. FURTHER ASSESSMENT USING RAP GUIDELINES

The RAP review and assessment process provides a time for staff to think about and discuss key areas of concern related to the resident. There are many ways to structure this assessment process, e.g. who leads the discussion or assessment, who participates, and how the resident, family and physician are involved. But in each case, staff should:

- Discuss the triggered problems and any current treatment goals and related approaches to care.
- Identify the key causal factors (i.e., why the problem is present).
- Review the associated and confounding factors referenced in the RAP Guidelines (i.e., things that contribute to the problem or add to the complexity of the situation).
- Ensure that information regarding the resident's status and clinical decision-making is documented, and that the RAP Summary form identifies where this documentation can be found.
- Proceed to Care Planning.

The following RAP Summary form indicates which RAPs were triggered for Mr. S., where documentation can be found, and whether a care plan has been developed. Before turning to the RAP Summary form, you may wish to review the MDS to determine which RAPs should be triggered. Using Delirium as an example, the following are examples of how staff might proceed.

1. As shown here, the Delirium RAP was used throughout the initial assessment period. It was clear from admission that Mr. S. had acute confusion. Predictably the Delirium RAP was triggered. Staff documentation throughout the first weeks of residency capture the key elements of the Delirium RAP assessment. The location and date of this documentation is entered on the RAP Summary form. The decision to care plan is indicated. As key information is clearly documented in this example and readily accessible to all staff, there is no additional documentation required beyond the RAP Summary form and referenced notations and care plan.

2. In some cases, a staff person may want to write a summary of the RAP assessment. This could be for several reasons: e.g., while the assessment documentation is in the record it is incomplete, unclear, too scattered or not focused. It may also be useful to have the information summarized for quick reference by staff. If this is the case, the summary note for Delirium could look like this:

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Numeric Identifier _____

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     - — Complications and risk factors that affect your decision to proceed to care planning.
     - — Factors that must be considered in developing individualized care plan interventions.
     - — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B.

1. Signature of RN Coordinator for RAP Assessment Process _____ 2. ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year

3. Signature of Person Completing Care Planning Decision _____ 4. ☐☐ – ☐☐ – ☐☐☐☐ Month Day

Delirium: RAP Summary Example 1

Mr. S. admitted from hospital with diagnosis of acute confusion. Since admission his cognition has steadily cleared. Indicators of delirium, such as being easily distracted, having altered perception or awareness of surroundings, and restlessness have lessened, but are not completely gone. Mr. S. has a history of Alzheimer's Disease, family have been very helpful in describing his baseline mentation. The team believes that delirium is related to his UTI, relocation, Haldol, Morphine, Zantac, and dehydration. To this end, his Haldol is being tapered with the goal of elimination (he was not on this drug prior to hospitalization), Morphine and Zantac have been discontinued, UTI has been treated with Bactrim DS - a follow up U/A C+S will be sent upon completion, I/O is being monitored and fluids being encouraged, and the family has been helping us simulate a homelike environment with Mr. S.'s possessions and routine.

Another example could look like this:

Delirium: RAP Summary Example 2

Mr. S. triggered for delirium. RAP was used as a guideline for assessment by team. (See nursing notes: 8/24/95, 8/28/95, MD note 8/25). Possible causal factors: UTI, Medication, Dehydration, Relocation have been identified and treatment plans are indicated. Refer to Delirium care plan.

4. CARE PLAN SPECIFICATION

The following is an example care plan for Delirium. It contains general points, rather than specific prescriptions. It is meant to show general culmination of the assessment process in the plan of care.

Objective	Intervention	Evaluation
Mr. S. will remain safe and have no injuries in next 30 days	Keep night light on in room at night. Have family bring in familiar articles (bedspread, pictures). 15 minute checks while in room, encourage out of room activities. Involve in low stimulus activities. Keep pathways clear and free from clutter. Toilet q 2 hours while awake and q 4 hours during night. Offer frequent snacks including beverages.	Resident remained safe in last 30 days, with no evidence of injury.

Mr. S.'s cognitive function will return to baseline[4] in 30 days	Taper Haldol as ordered. Continue to review all medications with physician. Assess for adequate hydration by monitoring daily fluid intake. Review requested notes from Adult Day Care to gain further insight into baseline. Continue with Tylenol for pain, give PRN dose before Physical Therapy and if resident appears agitated or withdrawn.	Resident's cognitive functioning appears similar to baseline [4] according to: family, documentation from Adult Day Care and cognitive clinic at hospital. Resident received Tylenol as ordered, and did not appear to be in pain.
Mr. S. and family will be acclimated to the unit in 30 days as evidenced by recognizing his own room and participating in unit activities with minimal supervision	Primary team to meet with family to work on care plan and tour unit. Involve family in all aspects of care. Assess family's level of knowledge about Alzheimer's disease and acute confusion. Reorient Mr. S. to his room and surrounding unit. As acute confusion begins to clear, involve Mr. S. in more of unit activities.	Family met with primary care team and toured the unit. Mr. S. is able to recognize his room and attend unit activities with a staff prompt.
Resident will maintain adequate nutrition and hydration over next 30 days as evidenced by eating at least 3/4 of his meals and drinking 2 liters of fluid each day	See urinary incontinence care plan. Carefully assess fluid intake from meal trays. Offer supplemental fluids in between meals. Involve family in determining the best fluids, Mr. S likes chocolate milk and apple juice. Review monitored intake and output sheets from last 7 days. Continue if intake is not at least 2000 ml/day. Monitor skin turgor and mucous membranes.	Mr. S.'s intake was at least 2000. Resident received supplemental beverages in between meal. Skin turgor is intact and mucous membranes are moist.

[4] Assumes description of baseline is documented elsewhere in the clinical record.

results from analysis of the resident by the interdisciplinary team based on communication about the resident that is reliable, consistent and understood by all team members. This benefits the resident by ensuring that the entire interdisciplinary team and all "hands on" caregivers are following the same process based upon a common knowledge base.

Properly executed, the assessment and care planning processes flow together into a seamless circular process that:

- Looks at each resident as a "whole" human being with unique characteristics and strengths.
- Breaks the resident into distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible problems the resident may have (Triggers).
- Provides additional assessment of potential problems by looking at possible causes and risks, and how these causes and risks can be addressed to provide for a resident's highest practicable level of well-being (RAP Guidelines).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident's care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the interdisciplinary team finalize the care plan after completing the comprehensive assessment:

1. The RAI process (i.e., MDS and RAPs) is completed as the basis for care plan decision-making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the interdisciplinary team that will develop the resident's care plan.
2. The team may find during their discussions that several problem conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problem condition may be overlapping, and consequently the interdisciplinary team may decide to address the problem conditions in combination on the care plan.

CHAPTER 5: LINKING ASSESSMENT TO INDIVIDUALIZED CARE PLANS

5.1 Overview of the RAI and Care Planning

Throughout this manual the concept of linkages has been stressed. That is, good assessment forms the basis for a solid care plan, and the RAPs serve as the link between the MDS and care planning.

This chapter provides a discussion of how the care plan is driven not only by identified resident problems, but also by a resident's unique characteristics, strengths and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful, practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning is one of looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the interdisciplinary team to observe and evaluate the resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the RAP process provides guidance to the staff on how to use this information to assess triggered problems and ultimately to arrive at a holistic view of the person.

Once the resident has been assessed using triggered RAPs, the opportunity for development or modification of the care plan exists. The triggering of a RAP indicates the need for further review which is carried out utilizing the Guidelines that have been developed for each RAP. Staff use RAP Guidelines to determine whether a new care plan is needed or changes are needed in a resident's existing care plan. It is important to remember that even though a RAP may not have been "triggered" in the assessment process, the interdisciplinary team must address, in the care plan, a resident problem in that area if clinically warranted. **(See Chapter 4 for additional information on the use and documentation of RAPs.)**

The care-planning process in long term care facilities has been the subject of countless books, journal articles, conferences and discussions. Often this discussion has focused more on the structure or content of care plans than on the course of action needed to attain or maintain a resident's highest practicable level of well-being. It is not the intent of this chapter to specify a care plan structure or format. Rather the intent is to reinforce that the care plan is based on using fundamental information gathered by the MDS, further review and assessment "triggered" by the MDS, and distillation of all final assessment information, through the RAP Guidelines, into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan

3. After using RAP Guidelines to assess the resident, staff may decide that a "triggered" condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.

4. The existence of a care planning issue (i.e., a resident problem, need or strength) should be documented as part of the RAP review documentation. Documentation may be done by individual staff members who have completed assessments using the RAP Guidelines or who participated in care planning, or as a joint note by members of the interdisciplinary team.

5. The resident, family or resident representative should be part of the team discussion or join the care planning process whenever they choose. The individual team members may have already discussed preliminary care plan ideas with the resident, family or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.

6. In some cases a resident may refuse particular services or treatments that the interdisciplinary team believes may assist the resident to meet their highest practicable level of well-being. The resident's wishes should be documented in the clinical record.

7. When the interdisciplinary team has identified problems, conditions, limitations, maintenance levels or improvement possibilities, etc., they should be stated, to the extent possible, in functional or behavioral terms (e.g., how is the condition a problem for the resident; how does the condition limit or jeopardize the resident's ability to complete the tasks of daily life or affect the resident's well-being in some way).

EXAMPLES

- Mr. Smith cannot find his room independently.
- Mrs. Jones slaps at the faces of direct care staff while they are giving personal care.
- Mr. Brown is unable to walk more than 15 feet because of shortness of breath.

8. The interdisciplinary team agrees on intermediate goal(s) that will lead to an outcome objective.

9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.

10. The parts of the goal statement should include:

    The **Subject** — the **Verb** — **Modifiers** — the **Time frame.**

EXAMPLE

Subject	Verb	Modifiers		Time frame
Mr. Jones	will walk	up and down 5 stairs	with the help of one nursing assistant	daily for the next 30 days.

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals or maintenance goals.

12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.

13. The final care plan should be discussed with the resident or the resident's representative.

14. The goals and their accompanying approaches are to be communicated to all direct care staff who were not directly involved in the development of the care plan.

15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.

16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among interdisciplinary team members.

5.2 The Care-Planning Process

In order to provide a backdrop for understanding care planning, how it is supported by the RAI process, and what is required by the regulations, this section has been organized around a **Question and Answer** format based on the interpretive guideline probes for the care planning requirements at 42 CFR 483.20. The appropriate **F Tags** have been added to the end of each question to guide the reader back to the regulation. The regulatory language and associated probes may be found in **Appendix P** of the State Operations Manual (SOM).

42 CFR 483.20 (d)(1)

Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? - F 279

The care plan is a guide for all staff to ensure that decline is avoided, if possible. Not only is the resolution of clinical problems important (e.g., treatment of a pressure ulcer), so is the prevention of further decline. For example, for the resident with pressure ulcers, a program of bed mobility as well as efforts at improving the resident's mood to increase willingness to get out of bed, will improve chances for slowing decline. There must be a realistic, directed effort to provide quality care in addressing immediate concerns while, at the same time, attempting to ensure that functional decline does not occur. This is "proactive" involvement by the interdisciplinary team to make sure that declines in resident functioning are avoided if possible.

How does the care plan attempt to manage risk factors? - F 279

The RAPs are excellent identifiers of resident factors that may increase the chance of decline or for a problem to develop. Risk factors must not be overlooked when designing an effective care plan. Through the RAP review, the interdisciplinary team can identify certain resident characteristics that put the resident at risk for problems. For example, a resident may suddenly become at risk for falls when a change is made to certain medications. The team should identify this potential risk and identify the necessary precautions as part of the care plan (e.g. orthostatic blood pressure checks for a period of time).

Does the care plan build on resident strengths? - F 279

Care planning is usually thought of as a facility staff effort to solve or eliminate resident problems. While this view is often valid, it is also important for the interdisciplinary team to carefully look at the resident's strengths and use them to prevent decline or improve the resident's functional status. The RAI process not only identifies concerns but also pinpoints areas of resident vitality. These strengths or areas of vitality should be used in the care planning process to improve resident quality of care and quality of life through improved functional ability and self-esteem.

Does the care plan reflect standards of current professional practice? - F 279

It is important for all facility staff to be aware of and utilize current standards of professional practice. This can be accomplished through a routine, up-to-date in-house training program or through the use of qualified external training resources. New and more effective treatment modalities, resident activities, etc. are continually being identified which will benefit residents if built into their care plans.

Do treatment objectives have measurable outcomes? - F 279

Measurable outcomes require current knowledge about the resident to establish a baseline (e.g. how many times does a resident behavior or symptom occur in a certain time frame or how does a resident experience pain). Next, a target, goal or outcome is required (e.g., reduction of behaviors to a certain level or reduction of pain). Finally, some way of measuring if the care plan has moved the resident from the baseline to the target outcome is needed. Without measurable outcomes there is no way to truly identify that a care plan has been successful. The care plan is a dynamic document that needs to be continually evaluated and appropriately modified based on measurable outcomes. This continual evaluation takes into consideration resident change relative to the initial baseline—in other words, if the resident has declined, stayed the same, or improved at a lesser rate than expected, then a modification in the care plan may be necessary.

Has information regarding the resident's goals and wishes for treatment been obtained — especially if a resident wishes to refuse treatment? Has the resident been given sufficient information about his or her treatment so that an informed choice can be made? - F 279

Residents should, if possible, be involved in planning their treatment. This means that staff must talk to the resident about what goals the resident would like to achieve and whether they believe these goals can be achieved. Residents also have a right to refuse treatment. The interdisciplinary team should ensure that the resident has all of the necessary information about how a particular treatment will affect the care they receive and their general well-being so that the resident can make an informed choice about whether or not they wish to receive treatment.

If a resident refuses treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? - F 279

If a resident refuses treatment, the team should seek options with the help of the attending physician, resident and family. Often one method of treatment may not be acceptable to a resident, but another choice of treatment may. For example, a resident may refuse to take a prescribed anti-depressant medication for treatment of depression. Alternative courses of action could be explored with the resident that would use the expertise of mental health professionals. Consequently, rather than a care plan which indicates only that a resident refused treatment, the care plan would reflect other goals and methods of addressing the problem(s). Involve staff who have regular, first hand knowledge of the resident (e.g., nursing or activity assistants) in reviewing possible options. They can provide insights on why the resident may be refusing care and how to devise a better approach to the problem.

42 CFR 483.20 (d)(2)

Was interdisciplinary expertise utilized to develop a care plan to improve a resident's functional abilities? - F 280

It is of the utmost importance that the staff most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and their family or other representative in the care planning process.

The medical model of care, while most common in the acute care setting, should not necessarily be the driving force in planning the resident's care unless the resident's medical condition is unstable and needs continuous clinical monitoring. The key is to identify those needs which affect the resident's day-to-day well-being. Such needs cover a broad range of areas and may vary among residents.

Although nursing staff are usually the "first responders" to resident problems and are responsible for the heaviest burden of documentation, each member of the interdisciplinary team brings a unique perspective and body of knowledge to the care planning process. As such, each members' contribution should be sought and valued.

In what ways do staff involve residents, families, and other resident representatives in care planning? - F 280

As emphasized in the Federal regulations as well as throughout this manual, the resident, resident's family or other resident representatives should be involved in the care planning process. The resident is the most appropriate individual to describe what is meaningful in his or her life. Family and friends may also contribute in a very meaningful way in describing what is important to a resident, especially for those residents who cannot speak for themselves. Although they may be knowledgeable about the resident and care practices, interdisciplinary team members do not know all of a resident's life history and experience which may affect his or her individual needs or dictate approaches.

It is important for the interdisciplinary team members to speak directly with the resident and the resident's family, friends and representatives during both the assessment and care planning process if an appropriate care plan is to be developed which will address all of the resident's individual quality of life and quality of care needs. If there is a legally designated proxy, staff should be aware of this fact and that individual should be given the opportunity to participate in the assessment and care planning process.

Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to the completion of the first comprehensive assessment? - F 282

Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status. Physician orders for immediate care (42 CFR 483.20 (a)/F 271) are the written orders facility staff need in order to provide essential care to the resident, consistent with the resident's physical and mental status at admission. These orders, at a minimum, should include dietary, medication (if necessary) and routine care instructions to maintain or improve the resident's functional abilities until facility staff can conduct a comprehensive resident assessment and develop an interdisciplinary care plan.

The interdisciplinary team may wish to conduct an initial RAP review for any identified problem or potential problem even before the MDS is completed. This review can be documented at the time, and a written update completed when the interdisciplinary team completes the RAI process and documents final care plan decisions.

For example, if a resident was re-admitted from the hospital with a physical restraint but the resident was not previously restrained, the interdisciplinary team should immediately assess the resident for the need for a restraint. Since the team would know that the Physical Restraint RAP would be triggered by the MDS, they would use the RAP to guide their assessment of the resident and make preliminary plans about how to handle the restraint issue. When the comprehensive assessment is completed, the interdisciplinary team would then make a final decision regarding the resident's current status and need for a restraint.

Similarly, if a resident is incontinent of urine at the first admission, or newly incontinent at re-admission, good practice would dictate that 14 days is too long to wait for completion of an initial assessment of the incontinence. Again, the Urinary Incontinence RAP can be used to guide the immediate care plan intervention. The documentation of the RAP review would then be updated following the completion of the comprehensive assessment.

Are direct care staff fully informed about the care, services and expected outcomes of the care they provide? Do direct care staff have general knowledge of the care and services provided by other staff and the relationship of those services to the resident's expected outcomes? - F 282

Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process. The importance of the communication between direct care staff and the interdisciplinary team cannot be overstated. Since direct care staff have the most frequent contact with residents, they may be the most knowledgeable about a resident's daily life, needs, problems and strengths.

Direct care staff who have not participated in the formal care plan decision-making process must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident's condition and well-being. Without knowing the reasons they are performing particular tasks, direct care staff may not understand the relationship between the care and services they provide for a resident and the expected outcomes for that resident. Similarly, for nursing staff to understand how the resident is responding to a plan of care, the input of direct care staff is crucial. In many ways, they are the best source of information on how the program has been implemented, how the resident has responded, and whether specific program variations might be useful.

What are some general care planning areas that could be considered in the Long Term Care setting? - F 280

The following are six general care planning areas that are useful in the long term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

<u>Functional Status</u>

Functional status limitations are identified using the MDS and triggers. All conditions determined to need care plan intervention, after using the RAPs to guide further assessment, must appear on

the care plan. The conditions identified by the RAI should be clearly linked to the problems addressed on the care plan.

Rehabilitation/Restorative Nursing

A resident's potential for physical, occupational, speech, psychological and other types of rehabilitation needs to be assessed and care planned. The risk of immobility, for example, should be assessed, and restorative nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions and the need for referrals.

Health Maintenance

Health maintenance includes monitoring of disease processes that are currently being treated. These would include both stable and unstable conditions that need monitoring such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

The interdisciplinary team may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled or need no monitoring. This will depend on the team's decision about how a given problem affects the resident's overall functioning or well-being.

Other areas of health maintenance may include terminal care, and special treatments such as peritoneal dialysis or ventilator support.

Discharge Potential

Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident's plan of care.

Medications

On at least a yearly basis, a comprehensive assessment of drug therapy should be completed (See 483.20 (b)(1)(2)(xiii)). This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facilities staff using Appendix N of the State Operations Manual on a monthly basis.

It is the interdisciplinary team's decision whether medications need to be addressed in the care plan. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications which may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The interdisciplinary team may decide to identify a drug(s) as an approach to meeting a goal. The interdisciplinary team should determine if any medications that the resident is taking are listed in a triggered RAP. If so, use of the medication needs to be assessed as a potential contributing cause to the RAP concern.

Daily Care Needs

Some facilities put all resident daily care needs and standard practice approaches on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Facility staff must use their professional judgment when making these decisions.

APPENDIX A

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